MAJOR MANAGEMENT CHALLENGES

Management Challenges Identified by VA's Office of Inspector General

The following is an update prepared by VA's Office of Inspector General (OIG) summarizing the ten most serious management problems facing VA, and assessing the Department's progress in addressing these problem areas. Although VA does not have specific quantifiable goals and performance measures in place to help resolve these problem areas, the Department does have corrective action plans in various stages of implementation. Progress will be monitored until each management challenge has been successfully addressed. Department officials have stated their agreement with the conditions the OIG reported. (On pages 89 to 101, the word "we" refers to the OIG.)

1. Health Care Quality Management (QM) and Patient Safety

Of the many challenges facing VA, one of the most serious, and potentially volatile, is the need to maintain a highly effective health care QM program. The issues that punctuate the importance of this challenge are VA's need to ensure the high quality of veterans' health care and patient safety, and to demonstrate to Department overseers that VA health care programs are effective.

One example of a particularly difficult and complex undertaking is the need to provide safe, high quality, patient care in an environment that is rapidly evolving from the traditional specialty-based inpatient care to the ambulatory care/ outpatient primary care setting. The more rapid pace of ambulatory care presents increased opportunities for clinicians to make errors in treating patients. The health care industry, including VHA, has not yet devised effective ways to quickly or accurately identify and correct such treatment errors. Thus, while patients are less vulnerable to hospital-acquired pathogens when they receive care in the ambulatory setting, they are increasingly vulnerable to incurring other medical treatment errors and threats to their safety.

Part of the problem is VHA management's inability to provide strong and consistent clinical quality management leadership at all levels of the organization. The devolution of management authority to the Veterans Integrated Service Networks (VISNs) and individual VA medical centers (VAMCs), coupled with resource reductions associated with the Veterans Equitable Resource Allocation (VERA) model, have led to greatly reduced numbers of clinical managers who are available to identify, evaluate, and facilitate the correction or elimination of clinical quality and patient safety issues. To complicate this problem, VHA managers have not devised any coherent functional descriptions and have not prescribed any consistent staffing patterns for medical center QM departments throughout the country. Thus, no two VAMC QM departments focus on the same issues in the same way. These functional and resource disparities severely impede the Department's ability to identify or measure the extent of possibly widespread unsatisfactory clinical care practices and to devise procedures to correct or eliminate such problems.

A fully functional QM program should be able to monitor patients' care to ensure their safety and to safeguard, to the extent possible, against the occurrence of inadvertent adverse events. This risk management function is intended to assure patients that they will be cared for in a manner that promotes their maximum safety while providing them with optimal medical treatment. Although VHA managers are vigorously addressing the Department's risk management and

patient safety procedures in an effort to strengthen patients' confidence while they are under VA care, patients continue to be injured in the course of their treatment. In particular, mentally or cognitively impaired patients continue to disappear from VAMCs, and several of these patients have died before searchers could locate them. Six VISNs have developed various patient safety initiatives to address this issue, but resolution of the problem does not appear to be imminent.

Current Status: This year, VHA responded to many of our recommendations to improve patient safety and QM activities. Although VHA has generally been responsive to our recommendations, some of the recommendations have gone unimplemented. We continue to work with VHA toward resolving the issues. To illustrate, in February 1998, we recommended that VHA determine whether its medical centers are effectively complying with policy and using the National Practitioners Data Bank during their credentialing and privileging reviews. VHA concurred with the recommendation and informed us that their Office of the Medical Inspector (OMI) would complete an internal review; however, this recommendation remains unimplemented. OMI recently received additional resources to complete this and other tasks, and we will continue to track this until all issues are resolved.

Conversely, VHA's establishment of the National Center for Patient Safety (NCPS) and national training on the principles of root-cause analysis represent an aggressive response to recommendations we made in past OIG Office of Healthcare Inspections reports. The focus that NCPS has placed on the issue of patient safety and on resolving long-time patient vulnerabilities will go a long way toward making sure that VA patients receive proper care in a safer environment.

In our report on VHA's policies and procedures for managing disappearing patients and associated search procedures, we made seven recommendations to improve VHA missing patient policies and controls. The Under Secretary for Health has concurred with our recommendations and provided responsive implementation plans.

We continue to review certain aspects of QM activities, specifically patient care and safety issues in VHA's community-based outpatient clinics (CBOCs), as part of our Combined Assessment Program reviews. We focus on making sure that medical center QM managers are monitoring CBOC patient care and safety data, and that corrective actions and follow-up activities are effective. These efforts fulfill our oversight responsibility to ensure that patients receive the same quality care at the CBOCs that they receive at the medical center-based clinics.

2. Resource Allocation

Resource allocation continues to be a major public policy issue. VHA management is addressing staffing and other resource allocation disparities as part of various initiatives to restructure the VA health care system. Some of the most significant initiatives include:

Resource Allocation Model

VHA hopes to correct resource and infrastructure imbalances by changing the method used to fund VAMCs. This methodology, called the Veterans Equitable Resource Allocation (VERA) model, was phased-in during fiscal years 1997-1999. VERA allocates funding to the VISN level based on workload (patients treated), rather than providing incremental increases based on prior year allocations. Such allocations have resulted in reduced funding to some VISNs that have seen significant reductions in workload.

Clinical Staffing Reductions and Adjustments

VHA has given VISN directors new authority to reduce physician levels in overstaffed specialties. Some networks have begun trimming and shifting staffing as part of consolidations, attrition, and

reductions-in-force. VHA is also reducing and reallocating its 1,000 resident training positions. We will continue to monitor VHA's progress in improving the balance in the distribution of staffing and other resources.

Improved Management Information/ Performance Measurement

In FY 1998, VHA began implementing a new cost-based data system to provide more useful performance measurement information on the resources (inputs) and workload produced (outputs) for clinical and administrative production units. Development of cost and performance measures for clinical and administrative activities will enable managers to evaluate their productivity and efficiency.

Current Status: In FY 2001, we will begin an audit to determine whether VERA equitably distributes operating budgets, furnishes sufficient funding to meet medical care needs, provides all veterans equal access to care, and identifies opportunities for VHA to enhance its resource allocation methodology.

Our review of the Decision Support System (DSS) standardization found that the potential usefulness of DSS and its data was compromised because some medical center staff had diverged from the system's basic structural standard. Where detected, such divergence had prevented medical center data from being accurately aggregated with data from facilities adhering to the standard. We were also concerned that undetected data divergences may have resulted in inaccurate data being aggregated into roll-up reports. Additionally, facilities diverging from the DSS structural standard could not perform a variety of analyses that adhering to the structural standard provides.

VHA's installation of DSS was intended to provide the types of management information that would have met the intent of the audit recommendations. Control of DSS standardization has been assigned to VHA's DSS Steering Committee and its Standardization Subcommittee. As of November 2000, implementation of the OIG recommendations regarding DSS standardization was still underway.

The OIG has an audit in progress to evaluate the process used by the Department to fill prescriptions written by private physicians and to quantify the number of priority veterans that use the Florida/Puerto Rico Veterans Integrated Network health care facilities for filling prescriptions. This work is expected to address the adequacy and availability of health care services in one VISN, result in recommendations that make additional resources available for the benefit of all enrolled veterans, and enhance the delivery of prescription services.

3. Claims Processing, Appeals Processing, and Timeliness and Quality of Compensation and Pension (C&P) Medical Examinations

VBA needs to continue improving the timeliness of benefits claims processing. Numerous studies, reviews, and audits have addressed timeliness and quality issues with VBA's C&P claims processing system, used for the annual administration of almost $23 billion in compensation and pension payments to veterans.

Claims Processing

For the past quarter century, VBA has struggled with timeliness of claims processing. Although some improvement has occurred in recent years, VBA still has a high workload backlog and takes an unacceptably long time to process claims. The inventory of pending compensation claims for FY 2000 averaged about 360,000; it took an average of 185 days for claims to be processed.

VBA has sought to address claims processing timeliness through improved training, organizational changes, and modernization efforts. Since 1996, the Department has completed two major reviews to devise ways to improve claims processing and restructure field operations. This effort was criticized by veterans service organizations, which were concerned that geographic reorganizations and consolidations would make it more difficult to provide veterans with effective representation.

Current Status: Because VA continued to fall short of achieving its claims processing goals, the Department is taking action to improve the accuracy of reported timeliness of claims processing. An OIG audit found that actual timeliness was well above reported timeliness. The Under Secretary for Benefits is taking aggressive action to assure that performance data covering benefits programs are accurately reported by all VA regional offices (VAROs).

Our 1997 "Summary Report on VA Claims Processing Issues" identified opportunities for improvement in the timeliness and quality of claims processing and in veterans' overall satisfaction with VA claims services. VBA is currently putting into effect its Business Processing Reengineering rules and the pension simplification team report that was highlighted in our audit report. The audit identified 18 regulatory changes considered necessary for full implementation of the Business Processing Reengineering. In response to the report recommendation, VBA has also developed an automated checklist to document evidence requests concerning each claim. The automated checklist is being used in the case management pilots at six VAROs. Unfortunately, VBA has not been able to take advantage of all these opportunities because of the long phase-in schedule projected for completing key improvements in processing claims. However, VA is firmly committed to implementing the remaining Business Processing Reengineering changes that have been evaluated and accepted.

Appeals Processing

Veterans have historically had to wait a long time to receive a decision on appeals of benefit claims. Large claims backlogs have continued to impact the Department's ability to provide veterans with timely service; in some cases, veterans have had to wait years for decisions on their claims. Increased appeals processing time has also resulted from the 1988 Judicial Review Act that established the U.S. Court of Appeals for Veterans Claims and expanded VA due process requirements. During FY 2000, the Board of Veterans' Appeals completed 34,028 appeal decisions.

Current Status: No Change.

Timeliness and Quality of C&P Medical Examinations

Disability benefit payments are based, in part, on interpretations of medical evidence by VBA disability rating specialists. That evidence is developed by VHA physicians, VHA-supervised physicians, or private contractors through examination of the claimant. Before receiving examination results, VBA cannot complete payment on claims. When a medical examination is not performed correctly, the veteran's claim is delayed until another examination is completed. This usually results in significant claim processing delays.

Our 1997 report, "Review of C&P Medical Examination Services," followed up on our 1994 recommendations to improve the timeliness of C&P examination services. We found that management had made some changes, but they had resulted in little improvement. We recommended that the Under Secretaries for Benefits and Health improve the quality and timeliness of C&P examinations by:

(i) establishing performance measures for their field facilities with the objective of reducing the number of incomplete examinations; (ii) requiring VBA area directors and VHA VISN directors to monitor progress in reducing the percentage of incomplete examinations; (iii) requiring VBA and VHA directors to work together to reduce the number of incomplete examinations.

Current Status: VHA and VBA have implemented our recommendations. In addition, VBA is collecting data in conjunction with a self-initiated contract disability examination pilot project.

4. Inappropriate Benefit Payments

VBA needs to develop and implement an effective method to identify inappropriate benefit payments. Recent OIG audits found that the appropriateness of C&P payments has not been adequately addressed.

Dual Compensation of VA Beneficiaries

A review of VBA procedures, in place to ensure disability compensation benefits paid to active military reservists were properly offset from their training and drill pay, determined the need for improvements to prevent dual compensation. We found that 90 percent of the potential dual compensation cases reviewed had not had their VA disability compensation offset from their military reserve pay. We estimated that dual compensation payments of $21 million were made between FY 1993 and FY 1995. If this condition is not corrected, estimated annual dual compensation payments of $8 million will continue. Dual compensation payments have occurred since at least FY 1993 because procedures established between VA and DoD were not effective, or were not fully implemented.

Current Status: VBA implemented two recommendations, but has not completed implementing the recommendation to follow-up on the dual compensation cases (fiscal years 1993 through 1996) to ensure either VBA disability payments are offset or DoD is informed of the need to offset reservist pay. VBA has also submitted a legislative proposal to allow the concurrent payment of reservists' drill pay and VA disability compensation for reservists with less than 100 days of drill pay in 1 year.

Payment to Incarcerated Veterans

Our review of benefit payments to incarcerated veterans found that VBA officials did not implement a systematic approach to identify incarcerated veterans and dependents and adjust their benefits, as required by Public Law 96-385. A prior audit conducted in 1986 found that controls were not in place to cut off benefits to veterans when they were incarcerated. In that audit, we recommended that a systematic approach be applied, but actions were not taken to implement those recommendations.

According to the Department of Justice, Bureau of Justice Statistics, federal and state prison populations more than doubled between 1986 and 1995, from 522,100 to 1,085,400. In addition, about 4.6 million individuals have been incarcerated and about 4.1 million inmates have been released from federal and state prisons between 1986 and 1995.

The current evaluation included a review of 527 veterans randomly sampled from the population of veterans incarcerated in 6 states. Results showed that VA ROs had not adjusted benefits in over 72 percent of the cases requiring adjustment, resulting in overpayments totaling $2 million. Projecting the sample results nationwide, we estimate that about 13,700 incarcerated veterans have been, or will be, overpaid about $100 million. If VBA does not establish a systematic method to identify these prisoners, additional overpayments totaling about $70 million will be made over the next 4 years to newly incarcerated veterans and dependents.

Current Status: Our recommendation that VBA enter into a matching agreement with the Social Security Administration (SSA) for prison records was implemented. However, our recommendations that VBA (i) identify and adjust the benefits of incarcerated veterans and dependents, (ii) establish and collect overpayments for released veterans and dependents that did not have their benefits adjusted, and (iii) establish a method to ensure that VAROs process identified cases timely and properly adjust benefits, are all unimplemented.

Payment to Deceased Beneficiaries

A February 1998 audit of VBA's current procedures to terminate beneficiary C&P benefits, based on information about veterans' deaths received from SSA, found that VBA needs to develop and implement a more efficient method to identify deceased beneficiaries and to terminate their C&P benefits. Based on information about veterans' deaths received from SSA, audit results showed that only 156 of a sample of 281 veterans reported by SSA as deceased were, in fact, deceased. C&P benefit awards for 42 of 156 deceased claimants were (i) still running, (ii) had incorrect termination dates, or (iii) had incorrect suspense dates. Overpayments in these 42 cases totaled $340,000. We estimate approximately $4 million in erroneous payments were made throughout VBA.

Current Status: VBA has implemented three recommendations, but has not completed implementation of the recommendation to correct errors in the electronic beneficiary database and to link other electronic beneficiary databases, where necessary.

Benefit Overpayments Due to Unreported Beneficiary Income

VBA's Income Verification Match (IVM) is a significant internal control and financial risk area because it did not produce the required benefit payment adjustments and identification of program fraud. Our audit found that opportunities exist for VBA to increase significantly the number of potential overpayments recovered through greater efficiency and effectiveness; ensure better program integrity and identification of program fraud; and improve delivery of services to beneficiaries.

To resolve these and other problems, VBA needs to address the following key findings: (i) increase the oversight and tracking of the IVM process; (ii) make the claims examina-tion process more effective; (iii) establish IVM-related debts; (iv) do not grant waivers of IVM-related debts when fraud is identified; (vi) increase recoveries by reducing the number of unmatched records; (vii) increase the number of referrals to the OIG for fraud. In conclusion, we found that the IVM process represents a potential material weakness area that should be monitored by the Department.

The potential monetary impact of these findings to the Department was $806 million. Of this amount, we estimate potential overpayments of $773 million associated with benefit claims that contained fraud indicators, such as fictitious social security numbers or some other inaccurate key data elements. The remaining $33 million is related to inappropriate waiver decisions, failure to establish accounts receivable, and other process inefficiencies. We also estimate that $300 million in beneficiary overpayments involving potential fraud had not been referred to the OIG for investigation.

Current Status: VBA agreed to implement the following recommendations: (i) increase program oversight of the results of IVM actions completed; (ii) eliminate the review of selected pension cases because they result in no benefit overpayment recoveries; (iii) eliminate review of IVM cases with income discrepancy amounts of less than $500 because they result in little or no benefit overpayment recoveries; (iv) complete necessary

data validation of beneficiary identifier information contained in C&P master records to reduce the number of unmatched records with SSA; (v) ensure that accounts receivable are established to recover IVM-related debts from beneficiaries; (vi) ensure that waivers of beneficiary IVM-related debts are not granted when fraud is identified; (vii) refer potential fraud cases to the OIG based on the established referral process; (viii) report the IVM for consideration as an Internal High Priority Area that needs monitoring.

Benefit Overpayment Risks Due to Internal Control Weaknesses

In the past year, the Under Secretary for Benefits asked for our assistance to help identify internal control weaknesses that might facilitate or contribute to fraud in VBA's C&P program. The request followed the discovery that three VBA employees had embezzled nearly $1.3 million by exploiting internal control weakness in the C&P benefit program. Our vulnerability assessment identified 18 categories of vulnerability involving numerous technical, procedural, and policy issues. The Under Secretary agreed to initiate actions to address these weaknesses.

To test the existence of the control weaknesses identified in the vulnerability assessment, we conducted an audit at the VARO in St. Petersburg, FL. The St. Petersburg office was selected for review because it was one of the largest regional offices, accounting for 6 percent of C&P workload, and it was the location where 2 of the 3 known frauds took place. The audit confirmed that 16 of 18 categories of vulnerability reported in our vulnerability assessment were present at the regional office.

Current Status: VBA agreed to address the internal control weaknesses identified in the vulnerability assessment and the 15 recommendations included in the St. Petersburg regional office audit. Implementation action on these recommendations is currently in process.

5. Government Performance and Results Act (GPRA)-Data Validity

GPRA requires federal agencies to set goals, measure performance against those goals, and report on their accomplishments. In accordance with the law, VA has set goals for each of its major business lines, identified related performance measures, and established procedures for compiling and reporting results.

Prior OIG audits have found erroneous data in many VA financial and management systems — medical care ($21 billion annually), compensation ($19.7 billion annually), pension ($3.1 billion annually), and education ($1.5 billion annually). Reliance on inaccurate data results in faulty budget and management decisions and adversely impacts program administration.

At the request of the Assistant Secretary for Policy and Planning, we initiated a series of audits to assess the quality of data used to compute the Department's key performance measures. We have completed audits of five performance measures[1]:

- average days to complete original disability compensation claims;
- average days to complete original disability pension claims;
- average days to complete reopened compensation claims;
- percent of the veteran population served by the existence of a burial option within a reasonable distance of place of residence;
- foreclosure avoidance through servicing (FATS) ratio.

[1] The three claims processing timeliness measures we audited have now been incorporated into a new key measure called average days to process rating-related actions.

After we identified deficiencies in each of the measures, VBA and VHA began taking action to correct the deficiencies.

VA has made progress in implementing GPRA, but additional improvement is needed to ensure stakeholders have useful and accurate performance data. Management officials continue to refine performance measures and procedures for compiling data. Performance data are receiving greater scrutiny within the Department, and procedures are being developed to enhance data validation. However, we continue to find significant problems with data input, and Department-wide weaknesses in our information system security limit our confidence in the quality of data output.

Current Status: Audits of two performance measures, the Prevention Index and the Chronic Disease Care Index, are in process.

6. Security of Systems and Data

VA needs to improve physical and electronic security over its information technology (IT) resources. The Department requires automated data processing (ADP) to manage transactions valued at over $28 billion annually and maintain over 40 million sensitive veteran records. Security risk increases as we share data with other departments and organizations. Multiple architectures and complex mission-specific systems throughout VA increase the risk of inappropriate access and misuse of sensitive data.

Historically, sufficient security has not been provided to safeguard VA IT resources. For example:

- risk assessments were not developed and maintained;
- center-wide and certain system security plans were not established;
- systems were not certified;
- numerous physical and electronic security controls needed to be implemented.

Current Status: Ongoing assessment of ADP controls is taking place. We are continuing our assessment of ADP controls as part of our audit of VA's FY 2000 Consolidated Financial Statements (CFS). In addition, we have initiated a nationwide audit of VA's Information Security Program to assess VA's efforts to address information security control weaknesses and establish a comprehensive integrated security management program. This audit will be completed, as required by the Computer Security Act and the new Government Computer Security Reform Act. The actions necessary to reduce risk to an acceptable level require a long-term, sustained effort. To address the VA-wide ADP security and control issues, VA established a centrally managed security group in FY 1999 and an information security working group, in which we participate. In October 2000, the Department issued a revised Information Security Management Plan that identified a number of security enhancement actions that are being accelerated to improve enterprise-wide information security. VA's Information Security Budget Program identifies 10 areas that VA plans to address during fiscal years 2000-2005, at an estimated cost of over $114 million.

In our audit of VA's FY 1998 CFS, we reported VA-wide information system security control as a material internal control weakness. The General Accounting Office (GAO) reached similar conclusions. Audit tests associated with our 1999 CFS audit demonstrated that widespread system security control weaknesses continue to exist in VA. As part of this audit, we contracted for "penetration tests" of VBA systems to assess the effectiveness of information system general controls. The review concluded that significant control weaknesses made VBA systems vulnerable to unauthorized access and misuse.

Additional penetration testing of VA systems will be completed as part of our nationwide audit of VA's Information Security Program. Our audit of C&P internal controls at the VARO in St. Petersburg, FL, also identified information security control weaknesses. In addition, we are evaluating the adequacy of Information Security Program controls as part of our cyclic Combined Assessment Program reviews of VA facilities. These reviews continue to identify security control weaknesses.

7. VA Consolidated Financial Statements

Some VA assets may not be adequately protected and resources may not be properly controlled. We issued an unqualified opinion on the Department's Consolidated Financial Statements for FY 1999, an improvement from FY 1998, when our audit opinion was qualified concerning Housing Credit Assistance (HCA) program accounts. While the Department achieved an unqualified audit opinion on the FY 1999 financial statements, three material internal control weaknesses remained, and VA remained noncompliant with the Federal Financial Management Improvement Act (FFMIA) in three areas.

The three material internal control weaknesses were: (i) VA-wide information system security controls; (ii) HCA program accounting; (iii)fund balance with Treasury reconciliations. The Department had made significant improvement, but needed to continue efforts to correct the remaining open information security and HCA recommendations and implement the new recommendations concerning fund balance with Treasury reconciliations. These internal control weaknesses expose VA to significant risks.

Our report on Compliance with Laws and Regulations stated noncompliance with FFMIA requirements concerning HCA program financial management information systems, information system security, and cost accounting standards. We also reported, as we had in previous years, noncompliance with one law that, while not material to the financial statements, warrants disclosure: the requirement for charging interest and administrative costs on compensation and pension accounts receivable.

Current Status: The Department has provided corrective action plans for the ADP security and control issues, with complete corrective action not planned until FY 2002. The audit of VA's FY 2000 Consolidated Financial Statements includes assessment of completed and in-process corrective actions by the Department on the other issues reported: Housing Credit Assistance and Treasury reconciliations.

8. Debt Management

As of September 1999, debt owed to VA totaled over $3.2 billion. This debt resulted from home loan guaranties, direct home loans, medical care cost fund receivables, compensation and pension overpayments, and educational benefits overpayments.

Current Status: The OIG has issued 15 reports over the last 6 years to address the Department's debt management activities. The recurring themes are that the Department needs to be more aggressive in collecting debts, improve debt avoidance practices, and streamline credit management and debt establishment procedures. Through improved collection practices, the Department can increase receipts from delinquent debt by tens of millions of dollars each year.

Over the past 30 months, audit coverage of VA's debt management program has focused on billing and collection of medical care copayments owed by veterans, or their insurance companies, for medical care of non-service-connected conditions, and overpayments

of compensation and pension benefits.

Our review of debt prevention, debt consolidation, and debt collection issues identified opportunities to avoid overpayments, establish debt, or improve collection of $260 million:

- establishment of $30 million in debts;
- prevention of new debts caused by benefit overpayments of about $81 million annually;
- need to enhance debt collection by about $130 million;
- need to streamline operations and achieve annual cost efficiencies of about $19 million.

In addition to realizing significant monetary benefits, these audits identified opportunities to enhance service to veterans by discovering benefit underpayments of about $14 million, and preventing the inappropriate billing or income verification of about 14,000 veterans.

We have issued several reports addressing income verification match issues. In our "Evaluation of VHA's Income Verification Match Program," a follow-up to implementation of our recommendations from prior income verification match audits, we reported that prior recommendations had not been fully implemented and that opportunities existed for VHA to conduct the program in a more efficient and cost-effective manner. We recommended that the Under Secretary for Health improve the income verification match program activities by: (i) requiring VHA's Chief Network Officer to ensure that VISN directors establish performance standards and quality monitors, and strengthen procedures and controls for means testing activities and billing and collection of Health Eligibility Center (HEC) referrals; (ii) requiring VHA's Chief Information Officer to develop performance measures and monitor periodic performance reports; (iii) expediting action to centralize means testing activities at the HEC. Our recommendations have not been implemented.

At the request of the Under Secretary for Health, we are auditing VHA's means testing and income verification program to: (i) ensure the HEC has purged all income information received from the Internal Revenue Service from electronic and hard copy records; (ii) review the steps taken by local VHA facility management to ensure compliance with legal requirements associated with controlling means testing data since January 1999, and whether additional measures are warranted; (iii) review the financial and administrative impact on VHA if an extended period of time elapses without income verification.

We have also issued several reports addressing ways to improve VHA's Medical Care Cost Fund program. VHA has reported implementation of all of our recommendations; however, we have not completed follow-up work to document the improvements.

We are currently auditing VA's Debt Management Center (DMC) to determine whether the DMC is: (i) pursuing all reasonable debt collection avenues to maximize collections; (ii) collecting from Federal employee debtors by establishing Federal salary deductions; (iii) using standards and criteria appropri-ately to write-off, waive, or suspend debts; (iv) operating according to the provisions of the Debt Collection Improvement Act of 1996.

9. Workers Compensation Costs

The 1916 Federal Employees' Compensation Act (FECA) authorizes benefits for disability or death resulting from an injury sustained in the performance of duty. The Department of Labor (DOL) administers the FECA program for all Federal agencies. The benefit payments have two components: salary payments, and payments for

medical treatment for the specific disability. Medical treatment includes all necessary care, including hospitalization. DOL indicates that payments made to injured Federal workers is about $1.8 billion annually for all Federal agencies, of which approximately $140 million goes to injured VA workers. These benefit payments are at risk to fraud, waste, and abuse.

After auditing VA's FECA program in 1998, we concluded the program was not effectively managed and that by returning current claimants to work who are no longer disabled, VA could reduce future payments by $247 million. (DOL calculates savings based on the age of the recipient at the time of removal up to age 70, the life expectancy of these individuals.) From our random sample, we also identified 26 potential fraud cases that were referred to our Office of Investigations. After reviewing the sample results, we estimated that over 500 fraudulent cases were being paid about $9 million annually. Similar conditions were reported in a 1993 OIG report.

In 1999, we completed a follow-on audit of high-risk areas in VHA's Workers Compensation Program (WCP). The audit found that VHA was vulnerable to abuse, fraud, and unnecessary costs associated with WCP claims in three high-risk areas reviewed: dual benefits, non-VHA employees, and deceased WCP claimants. We estimated that VHA has incurred, or will incur, about $11 million in unnecessary costs associated with WCP claims in these high-risk areas.

Current Status: The OIG developed a protocol package and handbook for enhanced VA oversight and case management of the WCP. Both documents discussed key elements of case management and fraud detection. The protocol package was customized for individual VISNs and included a list of specific cases for review.

The OIG continues to work with the Department to reduce WCP costs through individual VISN case management reviews, staff training, and aggressive investigation of identified fraudulent cases. Individual cases of suspected fraud have been referred to our Office of Investigations for review. After investigation and successful prosecution, judicial actions returned to VA monies fraudulently received.

The Department is also providing WCP staff training and assistance to selected VISNs and has held national conferences to provide a forum for training and discussion of WCP issues. While the Department has taken a number of positive steps to address WCP issues, implementation of recommendations included in our 1998 and 1999 audits have not been completed. Key actions remaining include:

- One-time review of all open/active cases. (VHA is in the process of initiating required case review work that is scheduled to be completed in FY 2001. These reviews will include cases identified in both the 1998 and 1999 audits. We have participated in training sessions for newly appointed VISN WCP Coordinators who will be overseeing case review work at their respective VISN facilities. The one-time review effort will use the case review methodologies that we recommended in the protocol and handbook packages.)
- Implementing the system modifications discussed in the report. (Implementation action has been delayed due to budget constraints.)
- Issuing policy and guidance on recording, tracking, and using "continuation of pay" information. (Implementation action cannot be completed until the HR LINK$ system platform is completed.)
- Removing Veterans Canteen Service and NCA employees from VHA's WCP rolls.

(Implementation action will be completed once the one-time review of cases is completed.)

Implementing these recommendations is essential for the Department to strengthen WCP case management and reduce program costs. Given the significance of the audit findings and the risk of program abuse and fraud, WCP continues to be a high priority area.

10. Procurement Practices

The Department spends over $5.1 billion annually for supplies, services, construction, and equipment. VA faces major challenges to implement more efficient and effective ways of ensuring the Department's acquisition and delivery efforts to acquire goods and services. A more coordinated and integrated approach is needed to make sure the benefits of acquiring goods and services outweigh the costs. High-level monitoring and oversight need to be recognized as Department priorities, and efforts must continue to maximize the benefits of competition and to leverage VA's full buying power. VA must also ensure that adequate levels of medical supplies, equipment, pharmaceuticals, and other supply inventories are on hand. At the same time, VA should avoid tying up funds in excess inventories.

Historically, procurement actions are at high risk for fraud, waste, abuse, and mismanagement. Vulnerabilities and business losses associated with theft, waste, and damage of information technology are known to be significant. Recent OIG reviews have identified serious problems with the Department's contracting practices and acquisitions. These reviews have identified the need to improve the Department's procurement practices in areas of acquisition training and oversight to ensure the competency of the acquisition workforce. Previous audits also support the need to provide adequate acquisition planning on a corporate basis, and to improve and coordinate national and regional acquisition planning efforts. Recent business reviews conducted by the Office of Acquisition and Materiel Management and the OIG at four VA facilities have identified significant problems relating to acquisition planning, training, inventory management, management oversight, and contract administration.

Inventory Management

OIG audits have found that excessive inventories are being maintained, unnecessarily large quantity purchases are occurring, inventory security and storage deficiencies exist, and controls and accountability over inventories need improvement. We found that, at any given time, the value of VHA-wide excess medical supply inventory was $64 million, 62 percent of the $104 million total inventory. Audits at 4 VAMCs found that about 48 percent of the $2 million pharmaceutical inventories were excess. Another audit at 5 VAMCs concluded that 48 percent of prosthetic supply inventories were excess.

Excess inventories occurred because VAMCs relied on informal inventory methods and cushions of stock as a substitute for structured inventory management. As a result of the successful transition to prime vendor distribution programs for pharmaceuticals and other supplies, VAMCs have substantially reduced their pharmacy inventories from previous levels. However, inventories continue to exceed current operating needs for many items. Recent reviews of prime vendor programs have identified acquisitions obtained at increased costs and waste.

Purchase Card Use

OIG reviews at selected VAMCs have identified significant vulnerabilities in the use of purchase cards. Work requirements have been split to circumvent competition requirements, and some goods and services have been acquired at

excessive prices and without regard to actual needs. Risk will escalate as purchase card use increases throughout the Department.

Scarce Medical Specialist Services

OIG reviews of scarce medical specialist contracts have expressed serious concerns about whether these contracts or agreements are necessary and whether costs are fair and reasonable. Our reviews have identified conflict of interest issues and proposed sole source contracts that lack an adequate business analysis, justification, or cost/ benefit assessment. Management attention is needed to develop policies that will ensure consistency in the use of VA's statutory authority and proper oversight of such activities.

Current Status: The OIG is working with VA and VHA logistics staff to improve procurement practices within the Department. The OIG continues to perform contract audit and drug pricing reviews to detect defective and excessive pricing; and to provide improved assurance over the justification, prioritization, accountability, and delivery of pharmaceuticals and other goods in VA's operations. VHA has made the development of an Advanced Acquisition Plan a priority.

Investigation of selected construction contracts, purchase card activities, and vehicle administration at the VAMC in Clarksburg,WV, is in progress.

VA's Response to the Office of Inspector General's Assessment

The Department has the following comments to add to the OIG's assessment of the management problems facing VA.

Dual Compensation of VA Beneficiaries

We have been communicating with DoD's Defense Manpower Data Center to reach a solution on this issue. Although experiencing some difficulty in obtaining accurate data from the military services, DoD is working on ways to capture the information we need to offset VA disability compensation against military reserve pay.

Payment to Incarcerated Veterans

We have initiated a project, scheduled for completion by the spring of 2001, for the programming necessary to conduct a match with SSA, using existing procedures. The system to identify and adjust the benefits will be identical to the existing system used for the Federal Bureau of Prisons.

Payment to Deceased Beneficiaries

We have placed a high priority on running a one-time match between the Beneficiary Identification and Records Locator System (BIRLS) and the compensation and pension master records to gauge the extent of the problem. To determine whether a First Notice of Death was processed, we will review every match between a BIRLS record with a date of death and a running compensation or pension award. We will then implement appropriate corrective measures.

GPRA — Data Validity

Inconsistencies identified in NCA's estimate of the percent of the veteran population served by a burial option within a reasonable distance of place of residence have been corrected.

Workers Compensation Costs

VHA recently completed its portion of outstanding actions regarding workers compensation costs. We have notified the OIG and are awaiting their response to our last update of the action plan.

Procurement Practices

The following additional actions have been taken to address this management challenge:

A task force composed of high-level personnel from the OIG, VHA, and VA logistics staff was formally chartered to tackle weaknesses in VA's procurement practices. On November 20, 2000, the group completed its findings and issued recommendations, which are now being studied for appropriate action.

VA has been working diligently to resolve problems in this area. Teams of experts have conducted business reviews of all acquisition and materiel management functions at our medical centers. An assessment by VA logistics staff of VHA's Inventory Management Program found that coordination and operation efficiencies provided by an integrated materiel management system have been adversely affected by VISN and medical center reorganizations. The Department believes implementation of the task force's recommendations will address the deficiencies that have resulted from VHA decentralization.

Also, VA is evaluating the acquisition training program to identify ways to improve the program's effectiveness. Identifying additional training methods beyond the classroom setting will strengthen the skills of our acquisition workforce.

Inventory Management

We accept the OIG's findings of the management challenges associated with procurement practices. However, the Department believes the OIG's finding of excessive VHA inventories is somewhat overstated. As we have discussed with the OIG, VA must be prepared to handle any medical procedure regardless of how rare it may be. Thus, many medical items must be kept on hand even though there may be little likelihood for use. Further, hospitals must have an adequate safety stock to make sure there is no outage of supplies. For these reasons, medical supply inventories will be higher than expected.

Management Challenges Identified by the General Accounting Office

In addition to those major management challenges previously discussed, the Department is facing other serious management problems identified by the General Accounting Office (GAO). The following discussion summarizes our efforts in FY 2000 to resolve identified problem areas. Some of the recommendations are taking considerable time to implement; monitoring will continue until implementation is completed. The background descriptions provided for these major management challenges came directly from GAO documents.

VA Lacks Outcome Measures and Data to Assess Impact of Managed Care Initiatives

Background: VA does not know how its rapid move toward managed care is affecting the health status of veterans because measures of the effects on patient outcomes or of changes in its service delivery have not been established. VA has recognized the necessity for, and the difficulty of, creating such measures. VA's challenge in assessing outcomes is further complicated by poor data. GAO and others have reported numerous concerns about VA's outcome data, including

inconsistent, incompatible, and inaccurate databases; changes in data definitions over time; and the lack of timely and useful reporting of information to medical center, VISN, and national program managers.

GAO's work on health care for Persian Gulf War and homeless veterans has resulted in eight open recommendations related to this management challenge. They involve the development and uniform implementation of a process to integrate diagnostic services, evaluate the effectiveness of treatment, and periodically reevaluate veterans with undiagnosed illnesses.

Status: In 1998, VA initiated five clinical demonstration projects for case management and multidisciplinary specialized Gulf War clinics. These projects complement a prior case-managed care initiative designed to improve service to veterans experiencing complex medical problems. In FY 2000, each Demonstration Project Principal Investigator submitted a final report addressing responsiveness to the initial proposal, scientific merit, innovative approaches, and relevance to Gulf War veterans' health.

The Gulf War Field Advisory Group met in December 1999 to create an evidence-based clinical practice guideline on Post-deployment Health Concern Evaluation and Management. A task force of this group met in July 2000 to develop another clinical practice guideline for the most common symptoms and difficult-to-diagnose, ill-defined, or medically unexplained conditions of Gulf War veterans. This effort is expected to result in a guideline that defines diagnostic and treatment strategies for care of patients with chronic fatigue syndrome and fibromyalgia. These clinical practice guidelines are joint VA-DoD initiatives.

In FY 2000, VA established national outcome measures to look at the functional status of all special population programs, except the seriously mentally ill. An outcome measure for this area is under development and should be available in FY 2001.

VA Faces Major Challenges in Managing Non-Health Care Benefits Programs

Background: In managing non-health care benefits programs, VA needs to overcome a variety of difficulties. Currently, VA cannot ensure that its veterans' disability compensation benefits are appropriately and equitably distributed because its disability rating schedule does not accurately reflect veterans' economic losses resulting from their disabilities. Also, VA is compensating veterans for diseases that are neither caused nor aggravated by military service. In addition, claims processing in VA's compensation and pension program continues to be slow, and the vocational rehabilitation program has had limited success. The data to measure compensation and pension program performance are questionable. Furthermore, VA has inadequate control and accountability over the direct loan and loan sales activities within VA's housing program.

Status: This challenge consists of several distinct elements and crosses program lines. We consider the first two challenges—ensuring that compensation benefits are appropriately and equitably distributed, and compensating veterans for diseases that are not caused by military service—to be policy issues requiring legislative or regulatory changes to effect. We do not consider them to be management challenges. The challenges concerning compensation and pension claims processing and data quality are addressed on pages 20-26, 83-84, and 89-91 of this report. The results of the vocational rehabilitation and employment program can be found on page 30. GAO made seven recommendations for VA's housing program. The two recommendations which address reconciliation of records in the

contractor's database with VA's general ledger are fully implemented; the one regarding prompt delivery of data to VA by servicers and trustees is substantially completed; and the other four, in connection with data base development and monitoring activities, are at various stages of implementation.

VA Needs to Manage Its Information Systems More Effectively

Background: VA lacks adequate control and oversight of access to its computer systems and has not yet institutionalized a disciplined process for selecting, controlling, and evaluating information technology investments as required by the Clinger-Cohen Act. While VA has progressed in addressing Year 2000 challenges, it still has a number of associated issues to address.

Status: VA fully implemented a capital investment process to track its major investments, including those for information technology (IT). Before being approved for funding, submitted proposals are reviewed by the VA Capital Investment Board (VACIB). Funded IT investments continue to be tracked within the context of the capital planning process through three primary means: (1) execution reviews, which provide for quarterly updates of project progress and comparison against planned costs and schedule; (2) in-process reviews, which independently assess progress of projects at discrete points during their development; (3) post-implementation reviews, which evaluate how well projects actually did against what was intended.

These tracking mechanisms produce information that is assessed by the Chief Information Officers' (CIO) Council for projects that significantly deviate from intended targets, defined as variances of more than 10 percent from planned costs and schedule goals. The CIO Council will determine appropriate remedial action, including making recommendations to the VACIB to either change the scope of project funding or terminate the project altogether. Such information also allows the VA CIO to provide the Secretary accurate and timely information on the status of investments in key information systems.

VA successfully transitioned into the Year 2000 (Y2K) without any significant computer-related incidents. VA benefits were paid on time, and our health care facilities remained open throughout the January 1 rollover.

VA completed health checks at our headquarters offices, medical centers, regional offices, national cemeteries, and data processing centers. These health checks found the facilities to be fully operational; no Y2K problems were encountered. VA has continued to deliver benefits and health care without any Y2K interruptions.

This successful transition into the Year 2000 reflects the hard work performed nationwide by VA employees to make our systems Y2K compliant. VA's Y2K program serves as a model for effectively managing IT needs throughout the Department.